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Papadopoulos I et al (2016) International study on nurses' views and experiences of compassion. *International Nursing Review*. (Pre-publication final draft)

Abstract

Background

Compassion is considered the cornerstone of nursing practice. However, the recent failures in delivering high quality compassionate nursing care in the UK's National Health Service have brought the topic of compassion to the attention of the public, service providers, policy makers and academics.

Aim

The aim of this study was to explore the nurses' views and experiences of a number of compassion-related issues in nursing and describe similarities and differences at an international level as well as from the different nursing roles of the participating nurses.

Methods

An exploratory, cross-sectional descriptive study, using an on-line survey. A total of N=1323 nurses from 15 countries completed the questionnaire.

Results

The majority of participants (59.5%) defined compassion as "Deep awareness of the suffering of others and wish to alleviate it" but definitions of compassion varied by country. 69.6% of participants thought compassion was very important in nursing and more than half (59.6%) of them argued that compassion could be taught. However, only 26.8% reported that the correct amount and level of teaching is provided. The majority of the participants (82.6%) stated that their patients prefer knowledgeable nurses with good interpersonal skills. Only 4.3% noted that they are receiving compassion from their managers. A significant relationship was found between nurses' experiences of compassion and their views about teaching of compassion.

Conclusion

Our study is unique in identifying the views and experiences of nurses from 15 different countries worldwide. The findings reveal that compassion is neither addressed adequately in nursing education nor supported in the practice environment by managers.

Limitations

Self-report bias was inherent to our survey study design. Furthermore, the individual cultural differences and similarities in the findings are difficult to extrapolate owing to the fact that our analysis was at country level, as well as at the level of the participating nurses.

Implications for Nursing Policy

Understanding the influence of culture on nurses' views about compassion is critical in the current multicultural health care environment and merits further research. This will potentially drive changes in nursing education (ensuring that compassion is taught to nurses) and in the way healthcare leaders and managers foster a compassionate culture within their organisations (for example, by leading by example and compassionate to their staff).

Keywords: Compassion, culture, international, nurses' views, quantitative, on-line survey

INTRODUCTION

The recent failures in delivering high quality nursing care in the UK National Health Service have brought the topic of compassion to the forefront and led to the development of the *Compassion in Practice* strategy (DH 2012). This articulates a vision for the development of a culture of compassionate care, but some critics have pointed out that the strategy fails to provide a clear direction to healthcare staff regarding compassionate behaviours and how to achieve them (Dewar et al. 2013a). Further, a recent literature review revealed the sparse available empirical evidence on the topic of compassion in healthcare and our limited understanding of the nature of compassion. In addition, it highlighted the lack of studies on compassion conducted in different countries and questioned whether there are cultural variations on the expression of compassion (Sinclair et al. 2016a). In an effort to start exploring possible cultural similarities and differences among countries and among different roles occupied by professional nurses, we conducted an on-line survey asking nurses from around the world to indicate their experiences and views on a number of current issues on compassion which have been raised in the literature and professional/public debates.

Background

Compassion has been defined as ‘a deep awareness of others’ suffering and a willingness to alleviate it’ (Goetz et al. 2010, Schantz 2007). It is distinguished from the concepts of empathy, sympathy or pity by the fact that healthcare professionals and patients establish authentic and meaningful relationships through which one’s suffering/pain can be understood and acted upon (Burnell 2009, Sinclair et al. 2016a).

Compassion is considered a fundamental element of patient-centred care (Bramley et al. 2014) and is associated with significant positive outcomes for palliative and end-of-life care (Sinclair et al. 2006b). In the healthcare setting, compassion satisfaction has been identified as a significant motivational factor for delivering high quality nursing care (Burtson et al. 2010). Being compassionate towards oneself has been deemed necessary, if an individual is to be compassionate towards others (Gustin et al. 2013). In addition, the institution’s environment either hinders or facilitates the expression of compassion (McCaffrey et al. 2015). Working in a compassionate environment has been suggested as an important

contributor to the delivery of compassionate care (Finfgeld-Connett 2008). In contrast, organizational pressures, working under unsupportive conditions and lack of time act as major barriers (Curtis 2013, Peters 2006 & Sinclair et al. 2016a). It has been found that an organization can contribute to the delivery of compassionate care by a) supporting staff in the engagement of self-compassion, b) finding ways for continuous involvement in compassionate care and c) assisting staff to experience satisfaction when delivering compassionate care (Dewar et al. 2014b).

Supporting nurses to engage in compassionate behaviours in the clinical environment has been strongly advocated (McSherry et al. 2012, Straughair 2012), especially after the recent failures in the UK National Health Service (Francis, 2013). According to Sabo (2011) constant caring for others might result nurses to experience compassion fatigue and feel uncared for. If unnoticed and unaddressed this may then result in absence from work and lack of job satisfaction.

Under the demanding conditions in which nurses often work, it may be difficult for them to care for self and display self-compassion. It is, therefore, necessary for other health-care professionals, particularly the managers, to be more mindful and show compassion to nurses working under them.

It is clear that compassion is essential for the wellbeing and care of patients and nurses as well as increasing the standards within the healthcare system. Research suggests that culture and compassion are linked. According to Larson (2014), Attree (2001), Goetz (2004) and Tweddle (2007), compassion is dependent on one's cultural background and spirituality. In addition, socio-political factors can have an impact on compassion. For example, individuals from countries where there is conflict or war have been found to be less compassionate (Goetz 2004; Stewart 2009).

Culture is defined as the collective programming of the mind which distinguishes the members of one group or category of people from another (Hofstede 2001). According to Hofstede (2001) culture is manifested at different levels, the deepest of which being that of values. Even though whole nations/countries should not be equated to one group, many

countries do form historically developed wholes which may consist of clearly different groups and less integrated minorities. Hofstede (2001) states that rightly or wrongly, collective properties are ascribed to the citizens of certain countries e.g ‘typically American’, ‘typically German’ and so on, although we wish to remind the reader that such labels should be used with caution.

A recent review demonstrated that what we mainly know about compassion is derived from research that has been conducted in Western countries and cultural variations on compassion have not been explored (Sinclair et al. 2016a). In today’s globalized world, nurses are world citizens, they care for diverse populations and come from different countries, and therefore it is essential to know whether or not cultural variations on compassion exist.

Aim

The aim of this study was to explore nurses’ views and experiences of a number of compassion-related issues in nursing. We also sought to explore similarities and differences at an international level, as well as from the different nursing roles of the participating nurses. We assumed that nurses’ views and experiences of compassion may differ between countries and cultures , and our survey – which consisted of structured and open ended questions- was set up to explore these views. This paper reports only the quantitative findings from this study (answers to structured questions).

Objectives:

To explore the similarities and differences in how nurses from different countries and cultures understand, define, give and receive compassion.

To investigate the views of nurses as to whether compassion is innate or needs to be learnt.

To investigate the source of compassion given to nurses and other healthcare professionals.

See table 1 for the full list of questions that were asked in this survey.

Design

An exploratory, cross-sectional descriptive study, using an on-line survey.

Development of the survey and procedures:

‘The international on-line Compassion Questionnaire’ survey was created by the first author (principal investigator) with questions based on key themes drawn out of published literature

within the field of nursing compassion, on-line nursing discussion forums, and public/professional blogs around the topic of compassion. The survey consisted of standalone open-ended and closed questions. Due to the exploratory nature of the study design, it was not possible to calculate measures of reliability.

The survey included questions about the definition of compassion, the importance of compassion in nursing, whether compassion can be taught, the level at which compassion is being taught, the nurses' experiences of compassion, their views on how a person develops compassion and their perceptions about the patients' preferences of care (please see Table 1 for specific survey questions).

In order to establish face and content validity of the questions we firstly piloted the survey among nurses from South Korea (N = 74). Nurses had the opportunity to comment on the questions and following the pilot, the questionnaire was slightly modified in order to improve the clarity of the questions. A summary of the pilot results is provided here:

The majority of Korean Nurses (50.7%) defined compassion as 'a deep awareness of the suffering of others and a wish to alleviate it'; they believed that compassion can be taught (64.4%) and that compassion is 'important' for nursing (67%). Many of them also felt that their patients prefer to be nursed by 'knowledgeable and compassionate nurses' (45%), and that nurses mostly experience compassion from their patients (80.9%).

In order to expand the study to include more countries and cultures the lead author sent out a call asking for volunteer collaborators with research experience from different countries to express their interest. This was an opportunistic, snowball sampling approach based on the modern principle of 'crowdsourcing'. Two volunteer co-researchers from each of the fifteen participating countries were recruited, the role of whom, was firstly, to comment on the questionnaire. As a result of this on-line discussion, questions were added to capture the participants' ethnicity and specific information about their job roles (e.g. qualified nurse, nurse teacher, final year student nurse). These changes further improved the cultural relevance and usefulness of the questionnaire thus contributing to the survey's face and content validity. Other roles for the co-researchers were the recruitment of participants, and the translation and back translation of the questionnaire into their native language to assure the quality and accuracy of the translation, using the World Health Organisation (WHO)

guidelines for instrument translation

(http://www.who.int/substance_abuse/research_tools/translation/en/). In addition co-researchers were asked to translate the participant invitation/information letter, as well as the collected qualitative data.

Recruitment of participants was carried out via the co-researchers from each country who distributed the survey to relevant groups and networks. Recruitment took place from January 2014 to April 2014. Individuals were eligible to take part if they were a qualified nurse, final year student nurse, nurse educator, or a nurse manager.

The invitation letter informed potential participants of the aim of the survey, the name of the ethics committee/s which provided ethical approval for the study, and emphasised that participation was anonymous, confidential and voluntary. Web-based electronic survey software was used to collect data. Participants were emailed a web-link to the survey which enabled them to complete the survey on-line. The electronic survey was presented in each of the host country's language. For participants who could not access the online survey, paper versions of the questionnaire were used. From the total of 1323 questionnaires, 179 were completed on paper as follows: Philippines: 100, Italy: 22, and Turkish Cypriot: 57.

The initial goal was to recruit 50 participants from each country, however most countries exceeded this target. The initial sample size goal for each country was not based on a power sample calculation since the nature of the project was exploratory and descriptive. Our intention was to ensure a reasonable sample size from each country that could provide the opportunity for comparisons between the countries. We refer to the list of the participating countries in the results section.

Ethical considerations

Ethics committee approval was obtained from the lead researcher's university (Middlesex University; ethics subcommittee; Health Studies, Application Ref: MHESC1401) and the participating co-researchers ensured that local country regulations were followed.

Data Analysis

The data from all countries were analysed using SPSS statistical software (version 22), and descriptive analysis was undertaken. Data were also compared between countries and relationships between variables were explored using chi square tests and analysis of variance

(ANOVA). Bonferroni post-hoc tests were employed when appropriate. Bonferroni correction was also applied when necessary in order to avoid Type 1 error in post-hoc subgroup analysis. The level of significance was set at $\alpha = 0.05$.

RESULTS

A convenience sample of N=1323 nurses responded to the survey from the following 15 countries: Australia (N=35), Cyprus¹ [(a)Greek Cypriots (N = 49) & (b)Turkish Cypriots (N =73)], Czech Republic (N=142), Greece (N=94), Hungary (N=87), Italy (N=53), Israel (N=81), Norway (N=29), Philippines (N=100), Poland (N=101), Colombia (N=103), Spain (N=174), Turkey (N=96), United Kingdom (N=56) and USA (N=50).

Out of the 1323 participants, the 45.4% were practicing qualified nurses. (Table 1) Overall the majority of the participants (59.5%) defined compassion as “Deep awareness of the suffering of others and wish to alleviate it” and the 69.6% thought that compassion was very important in nursing. Although more than half (59.6%) of them felt that compassion could be taught to nurses, 44.3% stated that not enough teaching about compassion is provided.

When asked for their views regarding patients’ preferences, the majority of participants (82.6%) thought that their patients prefer knowledgeable nurses with good interpersonal skills. Approximately half (51.1%) of them stated that patients value medical treatment more than compassion. When asked about the most important factor for the development of compassion, family, cultural values and personal experiences of compassion were rated similarly. Finally, participants were asked to indicate from whom nurses in their country experience compassion and surprisingly only 4.3% noted that nurses receive compassion from their managers.

The researchers carried out two sets of analyses. The first one focused on the differences amongst countries in regards to nurses’ definition of compassion, their views on teaching compassion and their experiences of compassion. For this purpose, an ANOVA was carried out and significant differences were found between the countries on their definition of compassion; $F(14,1106)=21.035$, $p<0.0001$, their views on the possibility of teaching

¹ Because of the current partition of the island of Cyprus we collected two separate sets of data in order to adequately represent the Greek and Turkish speaking Cypriots.

compassion; $F(15,1300)=5.226$, $p<0.0001$, the level of compassion being taught to nurses; $F(14, 1106)=5.254$, $p<0.0001$ and finally their experiences of compassion $F(14,1106)=7.838$, $p<0.0001$.

Due to significant differences found in the main analysis, further post-hoc tests were carried out in order to compare countries. A Bonferroni Correction was applied when necessary in order to avoid family-wise error.

The first set of post-hoc tests was carried out on the definition of compassion. Results showed that the majority of participants from Cyprus (both Greek and Turkish speaking), UK, and the Philippines defined compassion as “Empathy and Kindness”, whereas nurses from the other countries defined compassion as “Deep awareness of the suffering of others and a wish to alleviate it”; with nurses from Israel, Colombia and Spain overwhelmingly choosing this definition of compassion.

With regards to teaching compassion, participants from the Philippines were the most positive by stating “Yes, it is possible to teach compassion”. They significantly differed in their responses from those of the Turkish Cypriots, USA, UK, Czech Republic, Poland, Hungary and Italy, who were more likely to report that ‘No’ or ‘Do not know’ whether compassion can be taught. The majority of the participants from Philippines (57.6%) also reported that “The correct amount of teaching is provided”. They significantly differed in their responses from the respondents in other countries, particularly from the Spanish participants who were found to be the least positive with regard to the level of compassion teaching being provided. Furthermore, participants from Cyprus (Greek & Turkish speaking), Turkey, Greece, Poland, Hungary, Colombia, Norway and Israel, reported that “Some teaching is being provided”, and significantly differ from their Filipino and Spanish counterparts.

A final post-hoc test was carried out on nurses’ experiences of compassion. Results showed that Turkish (64.4%) and Greek Cypriot (66%) participants, along with those from the USA (56.5%), UK (66%), Greece (50%), Hungary (48.1%), Spain (50.6%), Australia (61.8%), Norway (60.7%) and Israel (62.2%), reported having experienced compassion mainly from

their colleagues. In contrast, those from the Philippines (51%), Italy (84.6%), Turkey (55.4%), Poland (55.7%), and Colombia (84.7%) indicated experiencing compassion mainly from their patients. Participants from Australia, Italy and Israel did not report experiencing compassion from their managers at all. Participants from the Philippines (39.6%) and Turkish Cypriots (20.8%) were the most likely to state that they experience compassion from their managers, as opposed to nurses from the other participating countries.

The second set of analysis was relational as the researchers wanted to assess the relationship between the nurses' experiences of compassion and the way they defined it, as well as their experiences of compassion and views on its teaching (See Table 2). Nurses' country of work was not used as a control variable for this analysis as the researchers wanted to assess the differences between the nurses' perceptions with regard to definition and the importance of compassion depending on the source of their received compassion. Those who stated that they experienced compassion from their managers were more likely to define compassion as "Empathy and Kindness", whereas those who reported that they experienced compassion from either colleagues or patients were more likely to define it as "Deep awareness of the suffering of others and wish to alleviate it" (See Table 2).

Nurses' thoughts on teaching of compassion and their opinions on the level of teaching being provided with regard to compassion also differed depending on their experiences of it. Most of the participants suggested that it is possible to teach compassion (See Table 2). However, those who stated that they experienced compassion from their managers were significantly more likely to say that "yes it is possible to teach compassion" ($t(52)=3.667, p=.001$) than those who reported receiving compassion from patients, who were significantly more likely to state that it is not possible to teach compassion ($t(52)=-10.215, p<.001$). Participants who stated that they received compassion mostly from their patients were also significantly more likely to say "Do not know" compared to those who reported receiving compassion from their managers ($t(52)=-24.097, p<.001$). No significant differences were found between the "Colleague" and "Patient" groups in terms of their views about whether compassion can be taught, ($F(1,1189)=1.687, p=0.134$) (See Table 2).

With regards to the amount of teaching provided, participants who stated experiencing

compassion from their managers were more likely than those who experience compassion from either “Colleagues” or “Patients” to say that the “Correct amount and level of teaching is provided”. The other groups were more likely to say “Not enough teaching is being provided”. Significant differences were also identified when the “Manager” and “Patient” groups were compared overall ($F(1,664)=39.920, p<0.001$). Those in the “Patient” group were significantly less likely to say that “The correct amount and level of teaching is being provided” ($t(52)=6.149, p<.001$) compared to those in the “Manager” group. They were, however, significantly more likely to say “Not enough teaching is provided” ($t(52)=-7.719, p<.001$) or “Do not know” ($t(52)=-14.653, p<.001$). Similar to the “Manager” and “Colleague” groups “Manager” and “Patient” groups did not differ significantly when stating “Some teaching is provided” ($t(52)=-0.785, p=0.436$). When comparing “Patient” and “Colleague” groups no significant differences were found ($F(1,1189)=0.385, p=0.403$).

Finally, an analysis of variance was carried out in order to assess whether the source of compassion differed amongst the occupation groups (final year nursing student, practicing nurse, lecturers/nurse educators). Overall there was a significant difference between the groups; $F(3,1168)=9.783, p<.0001$. Those who were practicing nurses were more likely to state that they experience compassion from their colleagues or from their managers compared to the final year nurse students (See Table 3). In addition, practicing nurses were less likely to state that they experience compassion from their patients compared to final year nurse students and the nurse educators/lecturers (See Table 3).

DISCUSSION

This is the first study to explore whether nurses’ definitions and experiences of compassion vary across countries, and as expected our results showed many similarities and differences between countries. In addition, we found that nurses’ perceptions of the source of compassion (whether they receive compassion from their patients, colleagues, and/or managers) were related to the way they defined compassion, their thoughts on whether compassion can be taught, and the level of teaching that is currently being provided. These interrelationships highlight the complicated nature of compassion and the need for further investigation of this topic.

The differences among countries in regards to the definition of compassion support the idea that one's cultural background and experiences has an impact on their views and in this case on how one defines compassion. The socio-political structures and their impact on compassion was also expressed by the participants in the open-ended questions which were reported in Papadopoulos et al. (2015); despite the differences on the chosen definition of compassion, nurses' enactments of compassion were very similar to patients' reported experiences and perceptions of compassionate care. 'Giving time, being there and getting to know the patient' are reported as significant expressions of compassion among patients (Bramley et al. 2014) and among the participants of this study (Papadopoulos et al. 2015).

In regards to whether compassion can be taught, nurses from Philippines were more likely to say 'yes, it can be taught'; they significantly differ from nurses of other countries. Although Aristotle (384-322BCE), suggested that compassion is a virtue mastered through practice and positive role modelling, there is considerable debate with regard to whether compassion is innate or learnt; our results reflect this debate. In supporting Aristotle's position an article by Barker et al. (2016) entitled 'Introducing compassion into the education of health care professionals; can Schwartz Rounds help?', concludes that the evidence from the Schwartz Rounds study conducted with medical students at University College London Medical School demonstrates that offering such educational interventions supports students to be more compassionate, both to themselves and others. However, Magalhães et al. (2012) reported that some students are more empathetic from birth and are therefore more likely to be caring and compassionate in their practice with or without receiving any specific training in compassion. This view was expressed by a sizeable minority of our sample (25%). However, this opposes the view of the majority of our sample, and that of other nurse educators and practitioners who believe that compassion is a skill that is developed during training (Kelley et al. 2013). Knowing that nurses' views on teaching of compassion differ is critical to the design of appropriate training methods and ways to develop and sustain compassion in a multicultural organization.

In addition, Milgram's experiments on obedience to authority (cited by Pence 1983) suggest that moral virtues such as compassion can be ignored or expressed depending on the behaviour of an authoritative figure. Therefore, it can be argued that if authoritative figures

such as managers and supervisors display compassion towards their employees (in our case nurses), it may encourage them to express compassion towards their patients and each other.

The positive impact of modelling by managers was also supported by the findings of our research whereby those who reported receiving compassion from their managers were found to be more positive regarding the possibility of teaching compassion. With the growing body of literature supporting the important role of leaders/managers on nurturing and enabling compassion in organisations, it is not surprising that if one receives compassion from their managers they will also be more positive with regards to teaching and nurturing it in others (Bramley et al. 2014, Cornwell et al. 2009, Gilbert 2009, Worline et al. 2006).

Although as suggested by Pendelton et al. (2002) and Rynes et al. (2012), managers play an important role in developing a compassionate culture at an organisational level, our study indicated that the large majority of nurses unfortunately seem to perceive that managers exhibit low levels of compassion. In accordance with our findings in a US sample only 7% of hospital employees reported receiving compassion from their supervisors (Lilius et al. 2008). We also found differences among countries with nurses from the Philippines and those from the Turkish speaking Cypriot group, reported receiving more compassion from their managers. This could be explained by the fact that relationships are valued differently in collectivist societies. In such societies people place more emphasis on interdependence, group harmony and group goals (Barkema et al. 2015) and that may strengthen compassion (Canevello et al. 2010). For example, Evans (2015) suggested that relationships are greatly valued in the Philippines (considered as a collectivist society) and individuals expect to be cared for with compassion empathy and listening, particularly during difficult situations (Lopez 2011).

Contradictory to these findings however, our results showed that similar to nurses from Australia, those from Italy and Israel who are also considered collectivist in their culture (Hofstede 2001) reported not receiving compassion from their managers. This may be explained by research reported by Storey et al. (2013), Dewar et al. (2011c); McCormack et al. (2008); Powell et al. (2009); and Smith et al. (2010) which suggest that in addition to cultural dimensions, other factors, such as efficiency, performance targets and fear of appearing unprofessional may influence managers to show less compassion towards their employees. The King's Fund (2012) warned healthcare managers that if only economic

factors and efficiency are perceived as important, it can have significantly adverse effects on the way employees feel about the value placed on their work as care-givers.

Recent research has suggested that in addition to one's cultural background, the culture of organisations is an important factor for the development of compassion (Dewar et al. (2011c); McCormack et al. (2008); Powell et al. (2009); Smith et al. (2010)). There is also evidence that organisations can create a co-operative environment for compassion by forming collective values, relations, personal skills and beliefs (Hegney et al. 2014). This consequently influences the employees' compassion towards themselves as well as others (Dutton et al. 2007).

According to Brodbeck et al. (2002), acceptable norms and behaviour are defined by societal and organizational culture. If compassion, therefore, is seen as an acceptable behaviour in a society or organisation, people are more likely to adopt such behaviour. If nurses experience compassion at work they are also more likely to be more compassionate to their colleagues and to patients in their care (Frampton et al. 2014).

Limitations

It should be noted that the snowball and opportunistic methods of sampling may have led to a selection bias. Moreover, owing to this type of sampling and resource limitations, it was not feasible to systematically approach participants from all countries to make sure that all parts of the globe were equally represented. Modern westernised countries may have been over-represented in our sample. For example, there was an under-representation of nurses from regions such as Eastern Europe, Africa, Asia, and South America. Inclusion of participants from these regions, which are known to be more collectivist, may have elicited slightly different results.

This was an exploratory study and the questions were mainly categorical. As this was the first time that the questions had been used, traditional tests of reliability and validity were not applicable. However, the initial piloting phase of the questionnaire was used to make necessary clarifications and changes to the questions, therefore improving the internal validity of the survey.

Moreover, due to the cross-sectional nature of the study it is not possible to detect causality. Some of the results may be prone to Type 2 error due to having a smaller number of

participants in some cells (see table 1). Furthermore, the individual cultural differences and similarities in the findings are difficult to extrapolate owing to the fact that our analysis was at country level.

CONCLUSION

As stated in the background section of this article, it is clear that compassion is essential for the wellbeing and care of patients and nurses as well as increasing the standards within the healthcare system. Our study is unique in exploring the views and experiences of nurses from 15 different countries worldwide, allowing us to identify differences and similarities in various aspects of compassion in healthcare practice and education. In summary, our findings suggest that one's cultural background and experiences influence the way they define compassion and although nurses feel that compassion is very important to nursing practice they are less likely to experience compassion from their managers. In addition, our findings reflect the existing debate on whether or not compassion can be taught and reveal that nurses' perceptions of the source of compassion were related to the way they defined compassion, their thoughts on whether compassion can be taught, and the level of teaching that is currently being provided.

Nursing is now a global activity with large numbers of nurses moving across the world in search for work and better opportunities. To achieve their successful integration in the host countries and to ensure that nursing is practiced with compassion we must first understand *how* nurses from around the world *define and experience* compassion.

Our findings highlight the need to urgently address the lack of compassion from managers to their nursing staff. As leaders, managers within organisations must lead by example and it should be their priority to create organisational structures that promote and sustain compassionate behaviours. Further research is necessary to better understand cross-cultural differences in views and expressions of compassion thus building on the baselines established by this exploratory study.

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Table 1: Number of Participants and Valid percentages on survey questions ($n = 1323$)

Survey Questions	Percentage (%)	N
Please select the option which applies to you		
I am a final year student nurse	9.9	131
I am a qualified practicing nurse	45.4	600
I am a nurse educator/ lecturer/or nurse manager	29.3	387

Other	8.0	106
Did not state	7.5	99
How would you define the term compassion?		
Empathy and kindness	28.2	370
Deep awareness of the suffering of others	9.3	122
Deep awareness of the suffering of others and a wish to alleviate it	59.5	780
Other	3.0	40
How important is compassion in nursing?		
Not very important	2.7	36
Important	27.6	364
Very important	69.6	917
Do you believe that compassion can be taught to nurses?		
Yes	59.6	784
No	25.2	332
Don't know	15.2	200
Do you believe that compassion is being taught to nurses?		
The correct amount and level of teaching is provided	11.1	145
Some teaching is provided	26.8	351
Not enough teaching is provided	44.3	581
Don't know	17.9	235
Do you think patients prefer to be nursed by:		
Knowledgeable nurses with good interpersonal skills	82.6	1082
Knowledgeable nurses with good technical skills	14.4	188
Knowledgeable nurses with good management skills	3.1	40
In your view, which is the most important influence for developing compassion?		
The person's family	30.5	400
The person's cultural values	34.2	449
The person's personal experience of compassion	35.2	462
Please select the statement you most agree with		
patients value efficiency more than compassion	32.7	414
patients value the use of medical technology more than compassion	16.1	204
patients value medical treatment more than compassionate caring	51.1	647
Please select the statement you most agree with		
Nurses in [country] experience compassion from their managers	4.3	53
Nurses in [country] experience compassion from their colleagues	46.3	582
Nurses in [country] experience compassion from their patients	49.4	622

Table 2: Descriptive Table Showing the Percentages and the Count of and the Relationship (X^2) Between the Nurse's Experiences of Compassion by Definition of Compassion, Perceptions of Teaching Compassion and the Level of Compassion Teaching that is being provided in Respondents' Countries of Work

Nurses' Experiences of Compassion			
	From Managers	From Colleagues	From Patients

		% (N)	%(N)	%(N)
How would you define the term compassion?	Empathy and Kindness	50.9%(27)	30.4%(177)	24.3%(151)
	Deep awareness of the suffering of others	5.7%(3)	10.6%(62)	7.6%(47)
	Deep Awareness of the suffering of others and a wish to alleviate it	43.4%(23)	55.9%(326)	63.8%(397)
	Other	0%(0)	2.7%(16)	3.4%(21)
Chi Square	$X^2(6,1250)=25.407, p<.001$			
Do you believe that compassion can be taught to nurses	Yes	77.4%(41)	60.4%(350)	58.5%(364)
	No	18.9%(10)	21.9%(127)	28.5%(177)
	Do not know	3.8%(2)	17.6%(102)	12.9%(80)
Chi Square	$X^2(4) =17.918, p=.001$			
Do you believe that compassion is being taught to nurses?	The correct amount and level of teaching is provided	49.1% (26)	9.7% (56)	9.7%(60)
	Some teaching is being provided	24.5%(13)	25.7%(148)	28.4%(176)
	Not enough teaching is provided	15.1%(8)	45% (260)	46.3%(286)
	Do not know	11.3%(6)	19.7%(114)	15.6%(97)
Chi Square	$X^2(6) =85.160, p<.001.$			

Table 3: Frequency Table showing the percentages of the Source of Compassion by Occupation Group

	Source of compassion		
	Managers	Colleagues	Patients

Occupation	Final Year Nursing Student	2.3%	40.8%	56.5%
	Practicing Nurse	7%	49.5%	41.8%
	Lecturers/Nurse Educators	1.6%	45.3%	49.9%